Supreme Court of the United States

October Term, 1989

[illegible] S. SALLES, *et al.*,

Petitioners,

v.

[illegible] HOSPITAL ASSOCIATION,

Respondent.

[illegible] the United States
[illegible] Fourth Circuit

[illegible]

[illegible] Jr.*

QUESTION PRESENTED

Whether a Medicaid provider has a cause of action under 42 U.S.C. § 1983 to enforce compliance with the provider reimbursement requirements of 42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. V 1987).

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IN THE

Supreme Court of the United States

October Term, 1989

NO. 88-2043

GERALD L. BALILES, *et al.*,
Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

On Writ of Certiorari to the United States Court of Appeals For the Fourth Circuit

BRIEF OF RESPONDENT

STATUTES AND REGULATIONS INVOLVED

The text of relevant statutes and regulations is set forth in the appendix to this brief.

STATEMENT OF THE CASE

In March 1986, respondent Virginia Hospital Association ("VHA") filed this action in federal district court against the petitioners, officials of the Commonwealth of Virginia sued in their official capacities ("defendants"), seeking declaratory and injunctive relief for violations of federal rights secured by Title XIX of the Social Security Act (the "Medicaid Act") regarding reimbursement of its member hospitals under the Virginia State Medicaid Plan ("state plan"). J.A. 3-4.

The state plan was amended effective July 1, 1982, creating a prospective reimbursement system for hospitals which established per diem reimbursement ceiling rates for peer groups of hospitals. The ceiling rates were based on the average cost per day of the median hospital in each peer group based on hospital cost reports for the year 1981, inflated to July 1, 1982. The ceilings were then set by increasing the medians by a reimbursement escalator. J.A. 16. A hospital's payments were set at the lower of its last fiscal year's average cost per day, adjusted by the escalator, or the hospital's peer group ceiling. Since 1982, the peer group ceilings have been adjusted periodically only through application of the reimbursement escalator based on a simple inflation index. The original medians have never been recomputed using more recent actual cost data. J.A. 12-13.

The VHA alleges that the reimbursement methodology adopted under the state plan has not escalated ceilings for all periods of inflation incurred and does not take into account a number of critical factors that cause hospital costs per day to rise at a rate higher than inflation. These factors include changes in technology; changes in care practices by physicians and hospitals; availability of nurses; treatment of more patients, both medical and surgical, in outpatient departments; decreases in average lengths of stay per hospital admission; and the increasing intensity of the inpatient services rendered per patient day. J.A. 14-15.

Despite implementing cost-saving measures which saved Virginia $19.8 million in 1986 alone, J.A. 50, and despite the fact that Virginia hospitals are low-cost health care providers based on a nationwide comparison of costs, J.A. 16, no hospital in Virginia is currently paid at a rate which meets its efficiently and economically incurred costs in providing services to Medicaid recipients. ¶ 10, Affidavit of

Mr. Rueben attached as Exhibit A to Respondent's Memorandum in Opposition to Application For Stay of Proceedings in the District Court Pending Disposition of Appeal, filed with this Court on October 23, 1989, by request of the Court.)

The VHA alleges that enforcement of the state plan violates its members' federal rights to reasonable and adequate reimbursement as a result of fundamental, systemic flaws in the methodology of the state plan. This suit is not about claims disputes; nor is it about individual hospitals objecting to the manner in which the state's reimbursement plan is applied to them. The VHA seeks prospective relief from the defendants' enforcement of a state plan which violates the hospital reimbursement requirements of the Medicaid Act.

SUMMARY OF ARGUMENT

For the past twenty years, hospitals that treat Medicaid patients have been accorded the right to sue state officials in federal court under 42 U.S.C. § 1983 (1982) to remedy state violations of the Medicaid Act's provider reimbursement standards, 42 U.S.C. § 1396a (a)(13)(A) (1982 & Supp V 1987). Congress has repeatedly acknowledged its awareness and approval of a Medicaid provider right to maintain such actions in federal court. Nevertheless, the defendants ask this Court now to revoke this right to sue by holding either that Congress never created a federal right, or that Congress intended to preempt the remedy under § 1983 by creating an alternative, comprehensive remedial scheme. The court of appeals below properly rejected both of these arguments.

In *Maine v. Thiboutot*, 448 U.S. 1 (1980), this Court confirmed what many federal courts had previously held (and what this Court had itself previously assumed)—that in enacting § 1983, Congress provided a cause of action to

redress the deprivation by state officials of "any right" secured by "the laws" of the United States. The holdings in *Thiboutot* and the line of § 1983 cases which followed it were reaffirmed less than a month ago in *Golden State Transit Corp. v. City of Los Angeles*, No. 88-840 (U.S. Dec. 5, 1989). Judged by the standards reiterated in *Golden State*, providers of Medicaid services clearly have an enforceable federal right to be reimbursed under a state plan that meets the federal provider reimbursement standard. This statutory requirement is not a mere expression of congressional preference, but rather, as Congress itself has consistently recognized, a legal obligation binding on those states which choose to participate in the Medicaid program. Under the language of the statutory provision, which is cast in mandatory, not precatory terms, "a state plan for medical assistance must provide for payment of the hospital . . . services." The provision in question was clearly intended to benefit hospitals, which are expressly identified as entities to whom payment is directly due.

The provision's central requirement—that a state plan must be designed to provide for reimbursement rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities"—is a standard whose enforcement has proven in practice to be wholly within the competence of the judiciary. The right of providers to have their costs reimbursed under a state plan that meets the minimum federal provider reimbursement standard is a right secured by the laws of the United States.

It is equally clear that the defendants have failed to discharge their burden of demonstrating that Congress created a comprehensive, alternative remedial scheme intended to supplant the § 1983 remedy. Congress has significantly reduced federal administrative oversight and has required the creation of a state appeals or exception process only for resolution of payment of individual claims

disputes. Furthermore, it has provided for no substitute private cause of action. No alternative forum exists for adjudication of a systemic challenge to the reimbursement principles of a state's Medicaid plan.

The legislative history and the overall purpose of the Medicaid provider payment standards clearly reveal Congress's intent to vest a federally secured right in providers and to preserve for them a § 1983 cause of action to protect that right. Each of the congressional revisions of the payment standards was enacted against a background of federal judicial protection of provider payment rights stretching back at least to 1969. Both the existence of a right and its enforceability in federal court were expressly acknowledged by Congress and the Secretary during consideration and enactment of legislation in 1976 which restored the states' eleventh amendment immunity from actions for damages, but which, it was expressly stated, did not affect provider suits for injunctive relief.

Congress's preservation of providers' substantive right and of their § 1983 cause of action plays an essential role in the overall Medicaid scheme. Congress has always recognized the close connection between adequate provider compensation and the success of Medicaid in affording medical care to those in need. Without a cause of action under § 1983, providers would have no effective means of raising the question of state compliance with the requirements of the Act.

ARGUMENT

I.

THE HISTORY OF THE MEDICAID LEGISLATION DEMONSTRATES THAT CONGRESS INTENDED TO AFFORD FLEXIBILITY TO THE STATES BY REDUCING FEDERAL ADMINISTRATIVE OVERSIGHT, WHILE RETAINING ACCESS TO FEDERAL COURT TO ENFORCE RIGHTS SECURED BY 42 U.S.C. § 1396a(a)(13)(A)

The history of Medicaid legislation demonstrates that since the inception of the Act in 1965 Congress has maintained a careful balance between ensuring that participating states provide for adequate funding for Medicaid services and encouraging the goals of efficiency and cost control. On a variety of occasions since 1965 Congress has returned to the Act with the intent of adjusting this balance; at no point in its frequent dealings with Medicaid, however, has Congress repudiated its original purpose of requiring states to comply with the fundamental federal standards governing their Medicaid plans. In addition, Congress has been careful to preserve for providers a cause of action for prospective relief as an essential remedy to protect their right to payment in accordance with the Act.

1. Section 1902(a)(13)(B) of the 1965 Act, Pub. L. No. 89-97, contained a specific provision addressing payment to hospitals for Medicaid services, expressed in mandatory language: "A State plan for medical assistance must . . . provide . . . for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan." This original payment provision set a basic pattern that has been followed in all subsequent revisions: a fundamental federal standard for

payment to hospitals obligatory upon participating states;[1] state authority to devise the particular method of carrying out the federal payment standard;[2] and some form of administrative oversight by the federal Secretary.

This congressional mandate that state Medicaid plans provide for payment to hospitals of reasonable costs was enforced both by the Secretary's review process and through hospital suits brought in federal court for equitable relief. In *Catholic Medical Center v. Rockefeller*, 305 F. Supp. 1268 (E.D.N.Y. 1969) (3-judge court), *aff'd*, 430 F.2d 1297 (2d Cir.), *appeal dismissed*, 400 U.S. 931 (1970), a group of hospitals brought an action against state officials predicated on § 1983, *see* 305 F. Supp. 1256, 1260 (interim opinion), *remanded*, 397 U.S. 820 (1970), and alleging that the state Medicaid plan was in conflict with the Act's reasonable cost payment requirement. The district court rejected the suggestion that federal court adjudication of this issue interfered with the Secretary's oversight, 305 F. Supp. at 1270 ("the court does not interfere with the Secretary's administrative powers, but effectively undergirds them"), held the state plan in violation of the Act, and issued a declaratory judgment which was affirmed on appeal. *Id.* at 1271.

Catholic Medical Center was not an anomaly; during the same period, this Court was affirming the availability of § 1983 actions "to resolve disputes as to whether federal funds allocated to the States are being expended in conso-

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[1] "Once a State voluntarily chooses to participate in Medicaid, the State must comply with the requirements of Title XIX and applicable regulations." *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985).

[2] The House report accompanying the Act observed that "payment may be made on various bases" while noting the congressional intent that state payment plans "approximate as closely as practicable the actual cost . . . of services rendered." H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965).

nance with the conditions that Congress has attached to their use." *Rosado v. Wyman*, 397 U.S. 397, 422-23 (1970) (recipient suit involving AFDC provisions of the Social Security Act).[3] Thus, it was against the background of federal court enforcement of the rights secured by the Social Security Act that Congress turned to revise the Medicaid hospital payment standard.

2. In the early 1970s, Congress concluded that the original payment provision of the Act had not proven entirely satisfactory. The Secretary had equated the Medicaid standard with the Medicare reimbursement formula, which "provoked sharp criticism for doing nothing to hold down the spiraling costs of medical assistance programs." *Massachusetts Hosp. Ass'n v. Harris*, 500 F. Supp. 1270, 1274 (D. Mass. 1980). Congress responded to these problems with the Social Security Amendments of 1972, Pub. L. No. 92-603. Congress concluded that the Secretary's interpretation of the hospital payment standard was too inflexible and that states should possess enough flexibility to "develop their own methods and standards for reimbursement." H.R. Rep. No. 231, 92d Cong., 2d Sess., *reprinted in* 1972 U.S. Code Cong. & Admin. News 5087. At the same time, the legislative history of the Amendments reflects Congress's continuing intention to require states to "pay the actual and direct cost of providing care." *Id. See also* S. Rep. No. 1230, 92d Cong., 2d Sess. 325 (1972). Section 232 of the Amendments[4] permitted states "generally, to develop their own methods of reasonable reimbursement of hospitals rather than being required to follow the medicare regulations," H.R. Conf. Rep. No.

[3] Two years later, summarizing *Rosado*'s holding, the Court stated "suits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act on the part of participating States." *Edelman v. Jordan*, 415 U.S. 651, 675 (1974).

[4] Former 42 U.S.C. § 1396a(a)(13)(D) (1976).

1605, 92d Cong., 2d Sess., *reprinted in* 1972 U.S. Code Cong. & Admin. News 5386, but required the states to obtain the Secretary's approval prior to implementation.

The federal courts correctly interpreted the 1972 revisions of the Medicaid provider payment requirements as intended to preserve for the states "great flexibility in the areas of cost-finding and rate-setting," *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 392 (5th Cir. 1980), without thereby withdrawing from providers the ability to vindicate their right to payment in accordance with the Act's standards.[5] The ability of providers to sue under various titles of the Social Security Act had "by now been well-established," *National Union of Hospital & Health Care Employees v. Carey*, 557 F.2d 278, 280 (2d Cir. 1976) (discussing standing).

3. In the mid-1970s several states imposed freezes on their Medicaid payment rates.[6] At least one state did so without first obtaining the Secretary's approval and persisted even after the Secretary cited it for non-compliance with the Act.[7] Fears were expressed that the existing administrative means for dealing with such state action

[5] *See, e.g., Massachusetts Gen. Hosp. v. Sargent*, 397 F. Supp. 1056 (D. Mass. 1975) (reasonable cost requirement enforceable through declaratory judgment); *Wisconsin Hosp. Ass'n v. Schmidt*, [1976-77 Transfer Binder] CCH Medicare & Medicaid Guide ¶27,818 (E.D. Wis. 1976) (injunction entered against state plan's violation of providers' rights under the payment provision).

[6] *See* H.R. Rep. No. 1122, 94th Cong., 2d Sess. 6-7 (1976) (letter from Department of HEW).

[7] *See State Compliance with Federal Medicaid Requirements: Hearings Before the Subcomm. on Health of the Senate Committee on Finance*, 94th Cong., 2d Sess. 3-5, 7-8 (1976) (statement of Stephen Kurzman, Assistant Secretary for Legislation, Department of HEW) (henceforth, "Statement of Assistant Secretary Kurzman").

were both too slow and too clumsy,[8] while the federal courts were incapable of providing "retroactive relief to providers who may have been injured" by state violations of the Act.[9] Congress responded, at the very end of its 1975 session and without full committee consideration, by enacting Pub. L. No. 94-182 (former 42 U.S.C. §§ 1396a(a)(13)(g) and 1396b(1) (Supp. V 1975)), which required that a state plan include a provision waiving the state's eleventh amendment immunity from actions for damages "with respect to the application of [the hospital payment provision] to services furnished" under Medicaid. The statute required the Secretary to impose a penalty of 10 percent of the federal Medicaid matching funds otherwise available to any state that failed in any quarter to include such a waiver, thus subjecting states to this penalty if, for whatever reason, they had not executed a waiver by March 31, 1976.

The waiver requirement generated vigorous opposition from the states, H.R. Rep. No. 1122, *supra*, at 4,[10] and it was repealed the following October. *See* Pub. L. No. 94-552. The legislative history of the 1976 repealer clearly

[8] 121 Cong. Rec. 42,259 (Dec. 19, 1975) (remarks of Sen. Taft) (the existing administrative remedy, which required total withholding of federal funds in areas of payment in which the state was not in compliance, "is such a severe move that it is inconceivable"); Statement of Assistant Secretary Kurzman, *supra*, at 4.

[9] Statement of Assistant Secretary Kurzman, *supra*, at 3 (citing states' eleventh amendment immunity from actions for damages).

[10] The legislative history of the statute repealing the waiver requirement indicates that some states objected to the constitutionality of Pub. L. No. 94-182, that many legislatures had found it literally impossible to comply by the date necessary to avoid the 10 percent penalty, and that virtually all the states were concerned, as was the Secretary, that the waiver would lead to litigation on matters unconnected with the particular problem of state plan non-compliance. H.R. Rep. No. 1122, *supra*, at 4-5; 122 Cong. Rec. 13,492 (May 12, 1976) (remarks of Rep. Rogers).

states Congress's intent that providers possess "legal rights" to payment in accordance with the Act. S. Rep. No. 1240, 94th Cong., 2d Sess., *reprinted in* 1976 U.S. Code Cong. & Admin. News 5650, rights that the repealer was in no way intended to affect. Both Congress and the Secretary unmistakably recognized that the providers' ability to protect their rights through federal court actions for equitable relief was neither created by the 1975 waiver requirement nor altered by the 1976 repealer.[11] The Senate report, after proposing that the Secretary adopt regulations to address the problem of state underpayment to providers, stated unequivocally that neither the development of such regulations nor the repealer itself should be "construed as in any way contravening or constraining the rights of the providers of Medicaid services" to seek equitable relief "in a federal or state judicial forum," *id.* at 4, 1976 U.S. Code Cong. & Admin. News 5651.[12] The defendants' assertion, Brief of Petitioners 21 ("Pet. Br."), that by eliminating damages actions against states Congress "*expressly rejected* federal litigation over this subject" is plainly wrong.

[11] *See* H.R. Rep. No. 1122, *supra*, at 4 ("providers could sue to enjoin action," in context clearly referring to federal court suits); *id.* at 7 (letter from Department of HEW) (after repeal of waiver requirement, "providers can continue, of course, to institute suit for injunctive relief in State or Federal courts, as necessary"); 122 Cong. Rec. 13,492 (May 12, 1976) (remarks of Rep. Rogers) ("the provider can sue the State to enjoin action"); Statement of Assistant Secretary Kurzman, *supra*, at 3 ("Access to Federal courts is available for injunctive relief against State officials."). The courts interpreted the repealer's effect in accordance with the congressional and executive understanding. *See, e.g., Hospital Ass'n v. Toia*, 435 F. Supp. 819, 831 (S.D.N.Y. 1977) (the repealer affected neither providers' "substantive right" nor their ability "to sue in federal court" for equitable relief).

[12] The regulations proposed by the Senate report, which the report expressly stated would not preclude judicial review, were far more extensive than those actually mandated by Congress in 1977, *see* 42 U.S.C. § 1396a(a)(37)(1982), or ever adopted by the Secretary.

4. In 1980 and 1981 Congress revised the Medicaid Act's requirements for state payments to providers,[13] adopting in successive sessions the basic requirement for nursing home and hospital payments now found in § 1396a(a)(13)(A). As in 1972, Congress intended to afford states "greater latitude in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services." H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981). Congress attributed much of the blame for the problems with the existing standards to the inefficiency, complexity and rigidity of the Secretary's administration of the Act,[14] and therefore acted to reduce sharply the Secretary's role in the administration of Medicaid provider payments and to effect "the removal of the burdensome costs, paperwork and frustration of Federal cost-reimbursement regulations." Statement of Sen. Boren, *supra*, at 848. Congress intended the Secretary to keep "regulatory and other requirements to the minimum necessary to assure proper accounting, and not to overburden the States and facilities" with red tape, S. Rep. No. 139, 97th Cong., 1st Sess. 478, *reprinted in* 1981 U.S. Code Cong. & Admin. News 744.

This reduction of federal administrative oversight was intended to result in "no reduction" in the responsibility of the states to abide by the Act's payment requirements. "On the contrary, the amendment would require accountability on the basis of results of the State's system rather than measurements of presumed compliances with a maze of regulatory and procedural details." Statement of Sen. Boren, *supra*, at 848. Just as before, the Act would forbid state plans from setting payment rates "lower than the applicable *legal requirements* would *mandate*." H.R. Rep. No. 1179, 96th Cong., 2d Sess. 154 (1980) (emphasis added). The legislative history unmistakably demonstrates Congress's unchanged intention to require states to pay providers in accordance with the (now revised) statutory standards.[15]

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[13] In 1980 Congress enacted the "Boren Amendment," Pub. L. No. 96-499, § 962(b), which established the current standard for payments to nursing homes. The following year, Congress extended the Boren Amendment, with certain additional requirements, to hospital payments, Pub. L. No. 97-35, § 2172. The combined 1980 and 1981 revisions are codified at the present 42 U.S.C. § 1396a(a)(13)(A). The VHA agrees with the defendants, Pet. Br. 19-20 & n.12, that the legislative history of both the 1980 and 1981 acts, as well as the nursing home portions of the 1979 Senate Report that first addressed the revisions, are relevant in determining the intent of Congress in enacting § 1396a(a)(13)(A).

[14] *See* S. Rep. No. 471, 96th Cong., 1st Sess. 28, 29 (1979) ("complex and long-delayed Federal regulations have unduly restrained [the states'] administrative and fiscal discretion" and imposed "marginal but massive paperwork requirements" on both states and providers); *Medicaid and Medicare Amendments: Hearings on H.R. 4000 (and All Similar Bills) Before the Subcomm. on Health and the Environment of the House Comm. on Interstate and Foreign Commerce*, 96th Cong., 1st Sess. 846 (1979) (statement of Senator David L. Boren) (henceforth "Statement of Sen. Boren"); (criticizing HEW's "unfortunate[]" adoption of "detailed and complex regulations"); H.R. Rep. No. 158, *supra*, at 292 (HHS administration of state proposals to use non-Medicare payment methods, an option intended to be available under the 1972 provision, "generally" compelled states to follow the Medicare basis).

[15] *See also* S. Rep. No. 471, *supra*, at 28-29 (amendment "gives the States flexibility and discretion, *subject to the statutory requirements of this section* and the existing requirements of section 1902(a)(30) and section 1121 of the Act") (emphasis added); *id.* at 29 (state flexibility "not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care"); S. Rep. No. 139, *supra*, at 478, 1981 U.S. Code Cong. & Admin. News 744 (same); Statement of Sen. Boren, *supra*, at 845 (amendment "places responsibility squarely on the States to establish adequate payments"); H.R. Rep. No. 158, *supra*, at 294 (state flexibility not intended "to result in arbitrary and unduly low reimbursement levels for hospital services"). During floor

In adopting the 1980 and 1981 revisions of the payment standards, Congress reiterated its belief that adequate provider compensation is a crucial element in the overall Medicaid program.[16] The defendants' assertion that the provider payment standards are merely preferred "goals" rather than a congressional mandate is flatly contradicted by the clear evidence of the legislative history of the 1980 and 1981 revisions. As the 1981 conference report stated, Congress "intend[s] that State hospital reimbursement policies should *meet the costs* that must be incurred by efficiently-administered hospitals in providing covered care and services to medicaid eligibles as well as the costs required to provide care in conformity with State and Federal requirements." H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. 962, *reprinted in* 1981 U.S. Code Cong. & Admin. News 1324 (emphasis added).[17]

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debate, Senator Boren was asked whether the revised standard would permit states to "set reimbursement levels so low" that they might not be "capable of meeting the costs of quality care." In response, the Senator explained: "[m]y amendment . . . achieves the present law's objective of assuring high-quality care" and "differs from the present law with respect to the methods States may employ in determining reasonable and adequate rates." 126 Cong. Rec. 17,885 (June 30, 1980) (colloquy between Sen. Pryor and Sen. Boren).

[16] "In permitting States greater flexibility in reimbursement system design, the Committee intends the States to ensure that such alternative systems provide fair and adequate compensation for services to Medicaid beneficiaries." H.R. Rep. No. 158, *supra*, at 293. Despite its goal of holding down Medicaid costs, Congress was careful to avoid suggesting that financial containment was a justification for inadequate payment rates. *See, e.g.*, H.R. Rep. No. 1479, 96th Cong., 2d Sess. 154, *reprinted in* 1980 U.S. Code Cong. & Admin. News 5903 ("The conferees would further note their intent that a State not develop rates under this section solely on the basis of budgetary appropriations.").

[17] The Secretary's interpretation of the current provider payment standards is in accord with the legislative history of the 1980 and 1981 revisions. In issuing the final regulations implementing the revisions, for example, the Secretary referred to "the explicit statutory responsibility of the State agency to make its finding that the methods and standards *result in* reasonable and adequate payment rates," 48 Fed. Reg. 56,046, 56,050 (Dec. 19, 1983) (emphasis added). The puzzling suggestion of the United States as Amicus Curiae that the Act "does not require that rates be reasonable and adequate," U.S. Amicus Br. 10, thus contradicts not only the plain import of the statutory language but also repeated assertions of congressional intent in the provision's legislative history.

5. The Court's "evaluation of congressional action . . . must take into account its contemporary legal context." *Cannon v. University of Chicago*, 441 U.S. 677, 698-99 (1979). With regard to the revisions in 1980 and 1981 of the provider payment standards, that context was shaped by an extensive history of congressional, administrative and judicial recognition that Medicaid providers possess a federally secured right enforceable by suits for prospective relief under § 1983.[18]

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[18] *See Samuels v. District of Columbia*, 770 F.2d 184, 194 n.7 (D.C. Cir. 1985) ("Absent affirmative indications to the contrary, then, we cannot assume that Congress implicitly intended to extinguish the plaintiffs' existing ability to enforce [their rights] under section 1983.").

Provider reimbursement suits against state defendants in the period immediately before the 1981 revision include *Massachusetts Gen. Hosp. v. Weiner*, 569 F.2d 1156 (1st Cir. 1978) (defendants prevailed on the merits); *Hospital Ass'n v. Toia*, 577 F.2d 790 (2d Cir. 1978) (claim for prospective relief moot); *California Hosp. Ass'n v. Obledo*, 602 F.2d 1357 (9th Cir. 1979) (judgment for plaintiffs vacated to allow Secretary to fulfill statutory duties); *Florida Nursing Home Ass'n v. Page*, 616 F.2d 1355 (5th Cir. 1980) (injunctive relief and availability of money damages upheld), *rev'd in pt.*, 450 U.S. 147 (1981) (eleventh amendment bars money damages); *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388 (5th Cir. 1980) (remanded to allow Secretary to fulfill statutory duties); *Alabama Nursing Home Ass'n v. Califano*, 433 F. Supp. 1325 (M.D. Ala. 1977) (plaintiffs prevailed on the merits); *Massachusetts Hosp. Ass'n v. Harris*, 500 F. Supp. 1270 (D. Mass. 1980) (complaint dismissed in part on eleventh amendment and mootness grounds); *Friendship Villa-Clinton, Inc. v. Buck*, 512 F. Supp. 720 (D. Md. 1981) (complaint dismissed on eleventh amendmentand mootness grounds).

II.

THE VIRGINIA HOSPITAL ASSOCIATION HAS PROPERLY ASSERTED THE VIOLATION BY THE STATE OF A FEDERAL RIGHT SECURED BY 42 U.S.C. § 1396a(a)(13)(A), A STATUTORY PROVISION BINDING STATES, BENEFITING PROVIDERS, AND WITHIN THE COMPETENCE OF THE COURTS TO ENFORCE UNDER 42 U.S.C. § 1983

In *Golden State Transit Corp. v. City of Los Angeles*, No. 88-840 (U.S. Dec. 5, 1989), this Court summarized the criteria for determining whether a federal right has been violated:

> In deciding whether a federal right has been violated, we have considered whether the provision in question creates obligations binding on the governmental unit or rather "does no more than express a congressional preference for certain kinds of treatment." *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 19 (1981). The interest the plaintiff asserts must not be "too vague and amorphous" to be "beyond the competence of the judiciary to enforce." *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 431-432 (1987). We have also asked whether the provision in question was "inten[ded] to benefit" the putative plaintiff. *Id.*, at 430; see also *id.*, at 433 (O'Connor, J., dissenting) (citing *Cort v. Ash*, 422 U.S. 66, 78 (1975)).

Id. at 3. Under these criteria, it is clear that § 1396a(a)(13)(A) of the Medicaid Act secures a federal right on behalf of providers to be paid at rates which are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities.

A. The Provider Reimbursement Provision Of The Act Is Not A Mere "Expression Of Congressional Preference" But Is Instead A Legal Obligation Binding On State Officials

As this Court made clear in *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981), not every violation of federal law is actionable under § 1983. When the provision in question secures a federal right to the plaintiff, however, a § 1983 cause of action does exist. In *Pennhurst*, this Court, recognizing "the well-settled distinction between congressional 'encouragement' of state programs and the imposition of binding obligations on the States," *id.* at 27, found that no substantive rights had been created by the statutory provision in question, § 6010 of the Developmentally Disabled Assistance and Bill of Rights Act. *Id.* at 11. The Court noted that the statutory provision relied upon by the *Pennhurst* plaintiffs was merely the preamble of the Title, setting forth the rationale for the conditions imposed by the remaining sections; *id.* at 24 n.18; that it was written "merely in precatory terms;" that it did "no more than express a congressional preference for certain kinds of treatment," *id.* at 19; that no authority was conferred upon the federal Secretary to withhold funds for state non-compliance with the provision, *id.* at 23; that the amount appropriated by Congress ($1.6 million) was so "woefully inadequate to meet the enormous financial burden" potentially imposed by the provision that "Congress must have had a limited purpose in enacting" it, *id.* at 24; and that given the "massive obligation" of providing treatment in "the least restrictive setting," *id.*, it is "unlikely that a State would have accepted [the small amount of] federal funds had it known that it would be bound to provide such treatment." *Id.* at 27.

In every material respect, the instant case is sharply different, and the principles of *Pennhurst* require recogni-

tion that a substantive federal right has been secured by the statutory provision in question. First and foremost, the language of the statutory provision is mandatory, not precatory. Unlike the statute reviewed in *Pennhurst*, the Medicaid Act does confer authority upon the federal Secretary to withhold funds for state non-compliance with the conditions of § 1396a. 42 U.S.C. § 1396c (1982). For states that elect to participate in the program, reimbursement of Medicaid providers is not an option "encouraged" by Congress, but a requirement flatly mandated by § 1396a(a)(13)(A): "A state plan for medical assistance *must* provide for payment . . . of the hospital . . . services . . ." (emphasis added).

It cannot be that this mandatory provision leaves states free to pay any amount they choose. The statutory requirement that participating states reimburse providers would obviously be meaningless if a state could, without limit, simply adopt any reimbursement method it chose, and pay as little as it wished. The statute requires that payment be made through the use of rates that the state finds

> are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services [that meet legal standards of quality and safety] and assure that [eligible] individuals have access . . . to inpatient hospital services . . . .

As the court of appeals concluded in *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11 (3d Cir. 1989): "[t]he language of this subsection is 'cast in the imperative . . . and succinctly sets forth a congressional command, which is wholly uncharacteristic of a mere suggestion or 'nudge' . . . in the direction of providing appropriate reimbursement of hospitals treating medicaid patients." *Id.* at 20.

The defendants and the Solicitor General suggest that the mandate that a state reimbursement plan satisfy these requirements does not actually impose any limitation whatsoever on a state's discretion to pay whatever it chooses. The only statutory requirement, as they would have this Court read the statute, is that the state make "assurances" to the Secretary. Whether those "assurances" are true or false is, in their view, irrelevant.

Statements that the statutory provision "does not require that rates be reasonable and adequate," U.S. Amicus Br. 10, and only requires "the submission of assurances" to the Secretary, Pet. Br. 15, ignore the fact that the statute expressly requires, before any assurances are made to the Secretary, that a state *find* that its plan will produce reasonable and adequate rates.[19] These requirements—(1) that the state find that its plan will meet the congressionally-mandated provider reimbursement standard; and (2) that the state make "assurances satisfactory to the Secretary" that it has done so—are separate and distinct. As Judge Posner noted in an analogous context: "The second requirement is a backstop for the first." *Edgewater Nursing Center v. Miller*, 678 F.2d. 716, 718 (7th Cir. 1982) (provider suit under 1972 nursing home payment standards). The defendants cannot satisfy the first requirement by arguing that they have met the second.[20] As

[19] The Secretary's regulations require each state to make annual findings that its reimbursement plan continues to meet federal statutory standards. Assurances to the Secretary, however, need not be made annually, but only when changes in payment methods and standards are made. 42 C.F.R. § 447.253(a) and (b) (1988).

[20] The defendants' assertion that the statute does not require that a state plan in fact provide for reasonable and adequate reimbursement, but requires only that "assurances satisfactory to the Secretary" be submitted to the Secretary, would ironically leave the Secretary with no basis whatsoever for finding any assurances unsatisfactory.

the history of congressional consideration of the provider reimbursement standard makes clear, see Part I, *supra*, Congress intended that states actually comply with the statutory standard, and not merely make self-serving findings of compliance.[21] The court of appeals below correctly concluded that "§ 1396a(a)(13)(A) reveals a congressional intent to condition federal assistance on states' achievement of the express purposes of the section and not simply on states' assurances of compliance" (footnote omitted). *Virginia Hosp. Ass'n v. Baliles*, 868 F.2d 653, 658 (4th Cir.), *cert. granted*, 110 S. Ct. 49 (1989).

Both states and Medicaid providers were clearly on notice that reasonable and adequate reimbursement to providers was mandatory for those states that chose to participate in the Medicaid program.[22] A state could not

[21] Other sections of the Medicaid Act refer to the provider reimbursement standard as a mandatory obligation, not as a mere goal or preference. See for example, 42 U.S.C. §§ 1396r-4(a) and (e) (1989 supp.) (referring to "the requirement" of § 1396a(a)(13)(A) regarding "payments to hospitals").

[22] In *Pennhurst*, this Court noted that Congress appropriated the "woefully inadequate" amount of $1.6 million for the state's program and could not reasonably have expected states to voluntarily undertake the "massive obligation" of totally restructuring their entire institutionalized persons system as a condition of receiving such small grants. 451 U.S. at 24. Here, in contrast, Congress has appropriated over $29 billion dollars for the Medicaid program, and pays from 50 to 83% of the total patient cost. U.S. Amicus Br. 2. It would thus be reasonable for both Congress and the states to assume that a state's decision to participate in the program carried substantial obligations.

Before 1981 states had been paying reasonable costs to all hospitals, not just those whose costs were efficiently and economically incurred. Rather than effecting the major expansion of services at issue in *Pennhurst*, the revision to the payment standard was intended to reduce costs under the Medicaid program. Section 1396a(a)(13)(A) does not require the states to take on massive new obligations, but

meet the "requirements" imposed by the Secretary's 1983 regulations without demonstrating that, under its plan, its "agency pays for inpatient hospital services . . . through the use of rates that are reasonable to meet the costs that must be incurred by efficiently and economically operated providers." 42 C.F.R. 447.253(a) & (b)(1)(i) (1988). Empty assurances do not satisfy this regulation. The Secretary's interpretation of the Act was that "the explicit statutory responsibility of the State agency" was to find that its plan would "result in reasonable and adequate payment rates." 48 Fed. Reg. at 56,050 (Dec. 19, 1983).[23]

There is no indication anywhere in the public record that any state was so cynical as to assume that it could—simply by making "findings" that were not in fact true—accept federal Medicaid funds while flagrantly failing to conform to the provider reimbursement standard. It was clear to everyone involved that the obligation imposed by Congress was not to be rendered wholly illusory by a state's arbitrary and capricious finding that its plan meets the federal statutory standard when it fails to do so in fact.

simply to pay reasonably and adequately for those services it has chosen to provide.

[23] Virginia asserts in its own plan that in accordance with these regulations, it "establishes payment rates that *are* reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities." Virginia State Plan, Attachment 4.19A at 4 (Sept. 1, 1988) (emphasis added), see appendix to this brief. Virginia is thus hardly in a position to claim that it was "unaware of the conditions [of receiving federal funds] or is unable to ascertain what is expected of it," *Pennhurst*, 451 U.S. at 17. The state plan, moreover, expressly asserts, not simply that "assurances" have been made to the Secretary, but that it in fact complies with the "reasonable and adequate" reimbursement requirement.

B. The Statutory Provision In Question Was Intended To Benefit Providers

In *Golden State*, this Court noted that in determining whether a statutory provision created a federal right, "[w]e have also asked whether the provision in question was 'inten[ded] to benefit' the putative plaintiff." Slip op. at 3.

The "provision in question" in this case was clearly "inten[ded] to benefit" providers. Hospitals providing treatment to Medicaid patients are directly and immediately benefited by the provision. The "statutory language" at issue is unquestionably "phrased in terms of the persons benefited": "A state plan for medical assistance must provide for payment . . . *of the hospital* . . . ." 42 U.S.C. § 1396a(a)(13)(A)(emphasis added). As the Court of Appeals for the Third Circuit noted, "[t]he section sets up a plan for the adequate and reasonable reimbursement of hospitals which serve medicaid patients, and thus the hospitals are the section's 'beneficiaries.'" *West Virginia Univ. Hosps.*, 885 F.2d at 20.

The defendants confuse the issue by suggesting that it is not sufficient that the statutory provision in question was "inten[ded] to benefit" providers.[24] The defendants and

[24] The defendants' confusion on this point arises from their belief that the decisions of this Court have now wholly merged two previously distinct lines of cases: those based on § 1983 and those in which this Court has, on its own authority and by implication, created a remedy where none has been provided by Congress. While there may be points of overlap in the analysis of the two lines of cases, the issue before this Court under § 1983 is in important respects fundamentally different from the issues raised when this Court is asked to create an "implied" remedial cause of action. As the Court of Appeals for the Fifth Circuit recently stated:

> To establish an implied private right of action under a federal statute, a plaintiff bears the relatively heavy burden of demonstrating that Congress affirmatively contemplated private enforcement when it passed the relevant statute. *See, e.g., Merrill Lynch, Pierce, Fenner & Smith v. Curran*, 456 U.S. 353, 377-78 (1982); *Cannon v. University of Chicago*, 441 U.S. 677, 688 (1979).
>
> Plaintiffs do not bear the same burden in seeking to establish a section 1983 right of action. The issue is not the intent of Congress to permit a section 1983 action, but rather the intent of Congress to withdraw the existing section 1983 remedy. The burden of establishing such intent rests on the defendant.

Victorian v. Miller, 813 F.2d 718, 721 (5th Cir. 1987) (citing *Wright*, 479 U.S. at 424).

The difference between the judicial standards applied in the two lines of cases arises from the critical fact that under § 1983 Congress itself has determined that in a limited category of cases—those in which a government official, acting under color of state law, has deprived a person of rights secured by the laws of the United States (and, if a state officer is sued in his or her official capacity, only insofar as prospective relief is sought) —federal courts should be available to provide a remedy. As Professor Sunstein has written, "[r]ecognition of a right of action under section 1983 avoids most of the problems associated with implied causes of action. Most fundamentally, the critical problem —that of judicial authority—disappears. . . . [B]y hypothesis, section 1983 authorizes the statute to be privately enforced. *Thiboutot* is in no sense inconsistent with the Court's curtailment of implied causes of action, but instead confirms the elementary proposition that the courts must recognize and enforce rights of action that Congress has created." Sunstein, *Section 1983 and the Private Enforcement of Federal Law*, 49 U. Chi. L. Rev. 394, 415-16 (1982).

If the same standards were to be applied in § 1983 actions as in "implied rights" cases, § 1983 would have no utility since a remedial action would be available under § 1983 only in those cases in which the Court would have implied a remedial action on its own authority. The defendants' suggestion that these two lines of cases be "merged" is thus, at a minimum, a suggestion that this Court's decision in *Maine v. Thiboutot* be overruled.

some of their amici suggest that this Court must look not to the statutory provision applicable to this case but rather to some larger statute (although they do not agree on which larger statute). They argue that Medicaid providers are not the intended beneficiaries of "the Medicaid program," Pet. Br. 15-16, or of "the Social Security Act," Brief for Connecticut *et al.* as Amici Curiae 2-3. But as this Court has stated

this Term, the relevant issue is whether the "*provision in question* was 'inten[ded] to benefit' the putative plaintiff." *Golden State*, slip op. at 3 (emphasis added). *See also Wright*, 479 U.S. at 433 (O'Connor, J., dissenting): "We have looked first to the *statutory language*, to determine whether it is 'phrased in terms of the person benefited.'"

The Court of Appeals for the Third Circuit recently provided the correct response to the defendants' argument:

> We recognize, of course, that the primary purpose of medicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it. It does not necessarily follow, however, that Title XIX grants substantive rights *only* to medicaid patients. Although the broad purpose of the Medicaid Act as a whole is to help the poor attain medical care, *the specific purpose of section 1396a(a)(13)(A) is to assure state compliance with some federal standard of hospital reimbursement.*

West Virginia Univ. Hosps., 885 F.2d at 20 (emphasis added). Here it is clear that a statutory provision specifying that a state plan "must provide for payment . . . of the hospital" was intended to benefit hospitals by ensuring adequate reimbursement for their services.

C. The Statutory Language And Decisions By The Federal Courts Enforcing The Provider Reimbursement Standard Clearly Demonstrate That The Provision Is Not "Too Vague And Amorphous" To Be "Beyond The Competence Of The Judiciary To Enforce"

The provision at issue in this case—the requirement that Medicaid providers be reimbursed, and that state plans provide for reimbursement rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities"—is not so

vague and amorphous that it cannot be considered legally binding. In *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418 (1987), this Court held that a regulation requiring a "reasonable" utilities allowance for public housing tenants was sufficiently capable of enforcement to be a federal right. *Id.* at 431. *Wright* established that a provision that contains the word "reasonable" is enforceable by the courts. While some statutes that contain "reasonableness" standards may not be within the capacity of the courts to enforce,[25] § 1396a(a)(13)(A) is not one of them.

Much depends upon the context of the phrase in the statutory provision. Like the "reasonable utilities allowance" in *Wright*, a standard requiring a reasonable and adequate ra.. for cost reimbursement contains ascertainable standards. It is possible, for example, to conclude with confidence that *some* methods of computing reimbursement rates are manifestly unreasonable.

In the instant case, the language of "reasonable and adequate" does not stand alone; it modifies "rates" and is addressed to the fit that Congress requires between the state-determined rates and the "costs" of an efficiently operated provider. While this type of required fit is one that does not pin down the rate-setter to a specific figure, it does require

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[25] For an example of a statutory provision that may be so vague and open-ended that Congress may well have concluded that "the [appropriate federal] agency, and not the court, has the primary responsibility to determine the statute's proper reach," *see* Sunstein, *supra*, 49 U. Chi. L. Rev. at 428 n.128, citing, among other examples, 7 U.S.C. § 136d(b) (conduct that "generally causes unreasonable adverse effects on the environment" is unlawful).

A requirement of reasonable and adequate reimbursement of costs is significantly more concrete than the example listed above. And, as shown in Part III, *infra*, Congress chose to reduce, not enhance, the federal administrative review of state plans, leaving the federal courts as the only body to provide effective enforcement of the requirements of the statutory provision.

that the rate-setting process be designed to produce rates that will fall within a "zone of reasonableness." *Wisconsin Hosp. Ass'n v. Reivitz*, 733 F.2d. 1226, 1233 (7th Cir. 1984).

The actual experience of federal courts in applying the reimbursement standard in litigation establishes that the standard is "not 'too vague and amorphous' to be 'beyond the competence of the judiciary to enforce,'" *Golden State*, slip op. at 3 (quoting *Wright*, 479 U.S. at 431-32). The decisions that have been handed down under § 1396a(a)(13)(A) demonstrate that the courts can identify clear instances of unreasonable and inadequate state plans. The Court of Appeals for the Tenth Circuit, for example, sustained a challenge by hospital providers in *AMISUB (PSL), Inc. v. Colorado Department of Social Services*, 879 F.2d 789 (10th Cir. 1989). In *AMISUB*, the state officials had developed a methodology for determining the reasonable cost of providing treatment to Medicaid patients and then simply reduced the amount to be paid by approximately one-half. The state officials' evidence at trial was "flagrantly devoid of any effort to make the federally required findings." *Id.* at 796. The "budget adjustment factor" that resulted in "a 46% decrease in provider reimbursement rates," the court found, "has no relation to the actual costs of hospital services." *Id.* at 792. As a result, "no Colorado hospital, no matter how efficiently and economically operated, will be reasonably and adequately compensated to meet the costs that must be incurred." *Id.* at 797.[26]

[26] The courts of appeals have demonstrated that meaningful criteria are available for distinguishing those instances in which providers have sustained their burden of showing that a state plan failed to meet the federal standard from those in which they have not. The same court that decided *AMISUB* rejected a nursing home provider challenge under § 1396a(a)(13)(A), *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 842 F.2d 1158 (10th Cir. 1988) (removal of certain incentive allowances for nursing homes does not violate federal requirement of reasonable and adequate payment).

West Virginia University Hospitals, Inc. v. Casey provides another example of egregious state non-compliance with the federal provider reimbursement standard. In that case, the provider alleged that the state plan for reimbursement of out-of-state hospitals serving in-state Medicaid patients fell far short of the floor established by Congress. Among other flaws, the plan failed, in violation of an express requirement of § 1396a(a)(13)(A), to take account of the added costs of an out-of-state hospital with a disproportionate share of Medicaid patients. 885 F.2d at 28. The court of appeals could find no "rational basis for [the out-of-state providers'] grossly diminished reimbursement rates," *id.* at 29, and concluded that it was "simply irrational and arbitrary" and "patently unfair" to utilize the plan's method "when the result is a system that varies so wildly in its reimbursement rates." *Id.* Where a state's policy results in unreasonable and inadequate reimbursement to hospitals, it is not beyond the competence of the court to conclude that the requirements of § 1396a(a)(13)(A) have not been met.[27]

The statutory provision at issue in this case thus meets all of the indicia of an enforceable federal right: its language is mandatory, the plaintiffs are among its intended beneficiaries, and its terms have proven amenable to competent

[27] The courts of appeals that have decided the issue whether providers have a secured right under § 1396a(a)(13)(A) have uniformly concluded that they do. *See West Virginia Univ. Hosps. v. Casey*, 885 F.2d 11 (3d Cir. 1989); *AMISUB (PSL), Inc. v. Colorado Dep't of Social Servs.*, 879 F.2d 789 (10th Cir. 1989); *Virginia Hospital Ass'n v. Baliles*, 868 F.2d 1308 (4th Cir.) *cert. granted*, 110 S. Ct. 49 (1989); *Coos Bay Care Center v. Oregon Dep't of Human Servs.*, 803 F.2d 1060 (9th Cir. 1986), *vacated as moot*, 484 U.S. 806 (1987); *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987); *Wisconsin Hosp. Ass'n v. Reivitz*, 733 F.2d 1226 (7th Cir. 1984). *See also Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511 (5th Cir. 1983).

judicial enforcement. This case differs from those in which courts must rely entirely upon these factors as a guide to whether Congress did or did not contemplate that its statutory provision would constitute an enforceable right. Here, there is simply no need to speculate. As shown in Part I, *supra*, Congress was clearly aware of, and expressly approved of, provider suits for declaratory and injunctive relief from state violations of the provider reimbursement provision.

The Solicitor General implicitly acknowledges that providers possessed a federal cause of action in 1976. See U.S. Amicus Br. 23 n.16. The 1975 Act of Congress requiring states to waive their eleventh amendment immunity (an act that permitted providers to obtain compensatory damages) would have made absolutely no sense if there were no underlying federal right. And the 1976 repeal of the eleventh amendment waiver provision would similarly have been utterly unnecessary if there were no underlying federal cause of action upon which to base suits for damages. Both the adoption and the repeal of the waiver of eleventh amendment immunity are predicated on the congressional understanding that the provider reimbursement provision creates a right enforceable in federal court. Nothing could be clearer than the numerous, consistent congressional statements that "providers can continue . . . to institute suit in State or Federal courts, as necessary." H.R. Rep. No. 1122, *supra*, at 7.

The Solicitor General's bald assertion, U.S. Amicus Br. 23 n.16, that some (unspecified) changes in the statutory language in the 1981 revision silently took away providers' right to sue cannot survive a comparison of the provider reimbursement provision in its 1972 and 1981 forms.[28]

[28] The 1972 hospital reimbursement provision required that a "State plan for medical assistance must . . . provide for payment . . . of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards . . . which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan . . . ." 42 U.S.C. § 1396a(a)(13)(D) (1972).

The 1981 revision of the provision imposed the additional requirement that the state's "methods and standards" of payment "take into account" the additional costs of hospitals serving a "disproportionate number of low income patients with special needs." The fundamental obligation to reimburse providers the costs of affording services to Medicaid patients, expressed in 1972 in terms of "reasonable cost," was rewritten in 1981 to require state plans to "provide for payment . . . through the use of rates . . . which the State finds . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . ." The revision also eliminated the requirement that the state plan, before its implementation, be "approved by the Secretary." 42 U.S.C. § 1396a(a)(13)(A)(1982).

Both the earlier and current versions of the provider reimbursement provision are set out in full in the appendix to this brief.

Far from having rendered the provider reimbursement provision amorphous, the 1981 amendment created a more detailed list of requirements for state plans. While it also lessened the role of the Secretary, this increases rather than weakens the case for judicial enforcement of the provision.

Since Congress has been expressly aware that providers have for two decades been able to enforce the provider reimbursement standard in federal court, and took specific actions in 1975 and 1976 premised upon that assumption, there is no reason for this Court now to presume that Congress did not intend its mandatory requirements to continue to secure rights enforceable in actions for prospective relief under § 1983. As shown in Part III, *infra*, Congress has chosen not to provide any comprehensive alternative remedial scheme, and to rely on providers' right

to sue in federal court as a check against failure by state officials to abide by the legal requirements that Congress has imposed.

III.

THE DEFENDANTS HAVE NOT DISCHARGED THEIR BURDEN OF SHOWING THAT CONGRESS HAS WITHDRAWN THE SECTION 1983 REMEDY BY CREATING A COMPREHENSIVE ALTERNATIVE REMEDIAL SCHEME: CONGRESS CREATED NO SUCH ALTERNATIVE SCHEME AND NONE EXISTS

As was shown in Parts I and II, *supra*, congressional consideration of provider reimbursement remedies during the 1970's establishes that Congress was fully aware of, and approved, provider suits for prospective relief as a remedy for violations of the reimbursement requirement. It is clear that Congress had not, prior to the 1980 and 1981 revisions, intended to create any comprehensive alternative remedial system that would oust providers' right to sue under § 1983. Since these revisions *reduced* the availability of the Secretary's review as a possible provider remedy, they could not conceivably have been intended as a new remedy ending access to state and federal courts under § 1983. Moreover, since the scope of any state relief is determined by each state, the defendants have made no showing whatsoever of any congressionally mandated, comprehensive, alternative remedial system that would establish a congressional intention to revoke the established right of providers to challenge the legality of state plans under § 1983.

A. Providers May Enforce Their Rights By Means Of A Suit Under Section 1983 Unless The Defendants Can Demonstrate That Congress Has Expressly Withdrawn The Section 1983 Remedy By Providing An Exclusive, Comprehensive Alternative Remedial Scheme

Even when a plaintiff has asserted a federal right, the defendant may attempt to show that Congress has expressly foreclosed a remedy under § 1983 by providing a comprehensive alternative enforcement mechanism for protecting that federal right. *See Golden State Transit Corp. v. City of Los Angeles*, No. 88-840, slip op. at 3 (U.S. Dec. 5, 1989); *Smith v. Robinson*, 468 U.S. 992, 1003 (1984). But the defendants bear the burden of demonstrating that Congress has withdrawn the § 1983 remedy, *Golden State*, slip op. at 3-4, and they must show that Congress expressly intended this result, *id.*, or in other words, that there is "a clear congressional mandate" to withdraw the § 1983 remedy. *See Middlesex County Sewerage Auth. v. National Sea Clammers Ass'n*, 453 U.S. 1, 31 (1981) (Stevens, J., concurring in the judgment). The Court does " 'not lightly conclude that Congress intended to preclude reliance on § 1983 as a remedy' for the deprivation of a federally secured right." *Wright v. Roanoke Redevelopment and Hous. Auth.*, 479 U.S. 418, 423-24 (1987) (quoting *Smith*, 468 U.S. at 1012 (1984)).

In attempting to discharge this burden, it is not enough to show the existence of alternative administrative remedies. "The availability of administrative mechanisms to protect plaintiff's interests is not necessarily sufficient to demonstrate that Congress intended to foreclose a § 1983 remedy." *Golden State*, slip op. at 3. *See also Wright*, 479 U.S. at 428; *Patsy v. Board of Regents*, 457 U.S. 496, 516 (1982). Nor is it enough that there exists the possibility of state-court judicial relief: a "state-court remedy is hardly a

reason to bar an action under § 1983, which was adopted to provide a federal remedy for the enforcement of federal rights." *Wright*, 479 U.S. at 429. *See also Monroe v. Pape*, 365 U.S. 167 (1961). The defendants must demonstrate that such alternative remedies were clearly intended by Congress to be the *exclusive* means of redress for aggrieved parties.

In *Wright*, for example, the Court acknowledged that there existed an extensive web of administrative mechanisms, including formal and informal hearings and administrative appeals conducted by impartial decisionmakers, all designed to process individual grievances. 479 U.S. at 426. The Court also acknowledged the federal agency's authority to conduct audits, enforce annual contributions contracts, and cut off federal funds. *Id.* at 428-29. In addition, the Court recognized that tenants could enforce their federal rights in state courts. *Id.* at 429. Yet the Court still concluded that this complex of remedies could not redress class grievances of the kind expressed by the tenants, and that these remedies were insufficient to evidence a congressional intent to withdraw the § 1983 remedy.

In *Sea Clammers*, on the other hand, the provision of an alternative remedial scheme was interpreted to express a congressional intent to withdraw the § 1983 remedy. The Court held that the presence in two federal statutes of "unusually elaborate enforcement provisions, conferring authority to sue . . . both on government officials and private citizens," 453 U.S. at 13, compelled the conclusion "that Congress provided precisely the remedies it considered appropriate." *Id.* at 15. The statutes authorized the federal agency to issue compliance orders and seek civil and criminal penalties; states were required to demonstrate that their officials possessed adequate authority to take enforcement action; interested parties were accorded

standing to seek review of actions of the federal agency in federal courts of appeals; and the statutes even contained citizen-suit provisions authorizing private persons to sue for injunctions. *See id.* at 13-14. It was the presence of private federal judicial remedies in *Sea Clammers* that was thought by the Court in *Wright* to be the crucial evidence of a congressional intent to supplant the § 1983 remedy. *See Wright*, 479 U.S. at 427.

For the defendants to prevail, therefore, they must demonstrate that Congress has created a system of provider remedies so clear and comprehensive that it unmistakably demonstrates an intent to foreclose a remedy under § 1983. This is a heavy burden, and the defendants have failed to discharge it. Not only are such federal and state remedies as do exist under the Medicaid statute, federal regulations and the Virginia state plan, fragmentary and incomplete, but they are highly uncertain as to their scope and effectiveness. Such "remedies" hardly constitute evidence of congressional intent to foreclose the § 1983 remedy.

B. Congress Has Provided Only Limited Federal Administrative Oversight And State Administrative Review

1. The defendants assert that the Secretary "vigorously enforces the Medicaid Act," Pet. Br. 23, and that "[t]his oversight is more direct, more intense and doubtless more effective than the casually-exercised HUD powers found in *Wright*." *Id.* at 24 n. 17. The Secretary, on the other hand, has gone to great pains to deny that he performs so extensive a role as far as § 1396a(a)(13)(A) is concerned. In *Illinois Health Care Association v. Suter*, 719 F. Supp. 1419 (N.D. Ill. 1989), where providers brought suit against the Secretary and state officials, the court granted the Secretary's motion for dismissal, agreeing that his role is "one that does not enmesh him in the details of the State's

compliance with the Act." *Id.* at 1423. Consistent with the Secretary's position, the United States in the present case has carefully avoided relying on the foreclosure argument in attempting to show that no § 1983 remedy exists. On the contrary, the United States acknowledges the limited nature of the supervisory role played by the Secretary. U.S. Amicus Br. 20-21.

The Secretary interprets his role correctly. He is vested with general powers to withhold approval of state plans, 42 U.S.C. § 1316(a) (1982), and to reduce or cease federal payments in respect of plans which no longer conform to the requirements of § 1396a or which are not being faithfully administered, 42 U.S.C. § 1396c. The statutory amendments, however, have changed his role from command-and-control supervision of state compliance with reimbursement requirements to simply determining that the assurances provided by the state are satisfactory. As in *Wright*, 479 U.S. at 428, the statute does not require and the Secretary has not provided any formal procedure for providers to bring to the Secretary's attention alleged violations of the Act or the regulations.

Under the decentralized process established by the 1980 and 1981 revisions, providers cannot expect significant protection from the Secretary.[29] The Secretary has interpreted his Department's new role narrowly and has revised

[29] It appears to be the practice of the Secretary, absent unusual circumstances, not to look behind the assurances made by the states to determine whether the findings upon which they are based are proper. Recently a federal district court found, on the basis of testimony by an official of HHS, that the Secretary "did not 'look behind' [Pennsylvania's] assurances concerning the adequacy of its reimbursement rates . . . nor did it require Pennsylvania to set forth the Commonwealth's specific findings concerning the adequacy of those rates." *West Virginia University Hospitals, Inc. v. Casey*, 701 F. Supp. 496, 510 (M.D. Pa. 1988), *aff'd in pt, rev'd in pt.*, 885 F.2d 11 (3d Cir. 1989).

state compliance requirements so as to "minimiz[e] the administrative burden." 46 Fed. Reg. 47,964, 47,969 (Sept. 30, 1981). While recognizing that § 1396a(a)(13)(A) stipulates various "basic conditions" with which states must comply, he has not "developed any standard methodology for States to use in ensuring that they meet these standards," believing that "development of this methodology should be the responsibility of each State." 46 Fed. Reg. at 47,970. Nothing in the approach of the Secretary suggests that providers are not entitled to such reimbursement as of right, but it is also clear that the Secretary has no intention of getting involved with disputes between providers and a state about state compliance with the requirements of § 1396a(a)(13)(A). Recourse to the Secretary is not a remedy available to providers by right and does not provide support for preclusion of a provider § 1983 remedy.

2. The Medicaid Act requires states to provide in their plans for the prompt reimbursement of provider claims, 42 U.S.C. § 1396a(a)(37)(A) (1982), and for prepayment and postpayment review procedures, "to ensure the proper and efficient payment of claims and management of the program." § 1396a(a)(37)(B). The Secretary has given effect to this provision through a rule requiring state Medicaid agencies to "provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to *such issues as the agency determines appropriate*, of payment rates." 42 C.F.R. § 447.253(c) (1988) (emphasis added). The states, in other words, determine the scope of administrative redress available to providers.

Virginia has responded by including within the provisions of its plan a three-tiered administrative appeal system. J.A. 32-43. Fundamental issues relating to the plan's

legality, however, are *not* appealable.[30] As the United States acknowledges, "[t]he Commonwealth's Medicaid appeals procedure precludes administrative review of the principles under the state plan." U.S. Amicus Br. 6. *By its own terms*, therefore, the Virginia appeals procedure precludes the very relief the VHA seeks in the present case.[31] The only court of appeals to have examined the issue of the required scope of state administrative appeals concluded that all that is necessary under federal law is a state process which provides for verifying the calculation of the payment rates. *See West Virginia Univ. Hosps.*, 885 F. 2d at 31. The state administrative appeal system cannot seriously be regarded as a sufficiently comprehensive remedial substitute for an action under § 1983.

C. The Avenues Of Judicial Redress Available Independent Of Section 1983 Cannot Provide Relief Against State Plans That Fail To Comply With Federal Law

The Medicaid Act contains no specific provision for judicial review at the instance of providers. In addition, the Secretary has taken the view that "[a]bsent any statutory mandate, there is no Federal authority to require judicial recourse (presumably in State courts) for providers dissatisfied with State payment rates." 48 Fed. Reg. at 56,052. Instead, the Secretary has indicated that providers must rely on "the current State administrative procedures or the

[30] Most important for the purpose of this appeal are the calculation of the initial group ceilings on allowable operating costs for inpatient care as of July 1, 1982 and the selection of the prospective escalator index. J.A. 33.

[31] The defendants seem to attribute significance to the fact that none of the VHA's members have pursued their appeals. Pet. Br. 7. The obvious explanation, however, is that the state agency has no jurisdiction under the state plan to consider the very issues the VHA's members wish to dispute.

State and Federal civil court systems." *Id.*[32] If any federal and state court remedies, other than those available under § 1983, were to exist, they would have to be found outside of the framework of the Medicaid Act itself—hardly a basis for the conclusion that Congress intended to withdraw the § 1983 remedy by the express provision of alternative remedies.

While there is nothing in the Medicaid Act that requires state court judicial review, and while the Secretary has specifically declined to impose such a requirement, the defendants attempt to demonstrate that the § 1983 remedy has been foreclosed by the availability, *inter alia*, of state court review under Article 4 of the Virginia Administrative Process Act, Va. Code §§ 9-6.14:15 - 9-6.14:19 (Repl. Vol. 1989). The happenstance of state judicial review—the availability of which is a matter of individual state law—is not a basis from which to deduce clear congressional intent to foreclose the remedy under § 1983. *See Wright*, 479 U.S. at 429. In any event, the availability of state judicial review in Virginia is, contrary to the assumptions of the defendants, Pet. Br. 23, and amici, U.S. Amicus Br. 6, extremely uncertain.

The Virginia Administrative Process Act specifically exempts from its application agency action relating to grants of state or federal funds. Va. Code § 9-6.14:4.1(B)(4).[33] The exemption has not been the subject of interpretation by the Virginia Supreme Court, but has been interpreted in a number of lower Virginia state court decisions and in the decisions of a Virginia federal district court and the federal court of appeals not to cover

[32] The Secretary's position was consistent with his previous representations to Congress. *See* Statement of Assistant Secretary Kurzman, *supra*, at 3 ("Access to Federal courts is available for injunctive relief against State officials.").

[33] This exemption was formerly contained in Va. Code § 9-6.14:20, the contents of which were consolidated into the present provision in 1985.

agency action involving public assistance. *See Harris v. Lukhard*, 547 F. Supp. 1015, 1033 (W.D. Va. 1982), *aff'd*, 733 F.2d 1075, 1081-82 (4th Cir. 1984) (citing and relying upon unreported Virginia decisions).[34] In the light of these decisions, both the provider-party and the state agreed, in *Mary Washington Hospital v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985), that the Virginia APA was not applicable to agency actions affecting Medicaid. *Id.* at 897. This is still the case.[35] Neither the defendants[36] nor amici,[37] identify

[34] After having previously taken a different view, the Attorney General of Virginia, in two 1982 opinions, apparently also took the view, relying on the grant-of-public-funds exemption and in the light of the opinions of the federal district court and Virginia circuit courts, that the Virginia APA did "not apply to the activities of the Virginia Medicaid Program." *See Harris*, 733 F.2d at 1082; Stump & Hanken, *Virginia Should Open its Courthouse Doors to Review Administrative Decisions Involving Public Assistance*, 21 U. Rich. L. Rev. 161, 164 n. 31 (1986).

[35] In 1989, the Virginia APA was amended and individual case decisions regarding the grant or denial of Medicaid were rendered subject to the APA's judicial review provisions. Va. Code § 9-6. 14:16(B) (Repl. Vol. 1989). But the availability of review was restricted in almost identical a fashion to the way in which the administrative appeals process applicable to providers has been limited. The amendment states: "no appeal pursuant to this article may be brought regarding the adequacy of standards of need and payment levels for public assistance programs . . . *The validity of any statute, regulation, standard or policy, federal or state, upon which the action of the agency was based shall not be subject to review by the court.*" *Id.* (emphasis added). If it is § 9-6.14:16(B) that provides the basis for judicial review of state plans, then the express terms of the Virginia Act itself prevent providers from challenging the underlying validity of those plans, and meaningful state judicial review would be unavailable.

[36] The defendants point to § 32.1-325.1 of the Virginia Code, Pet. Br. 23, which became effective on April 3, 1986. Va. Code § 32.1-325.1 (Cum. Supp. 1989). This section, which governs individual determinations by the state agency as to whether overpayments have been made to providers under the state plan, instructs the agency to undertake recovery of overpayments to providers. It also affords providers the

any plausible basis for state judicial review. Even if the availability of state court review were relevant in discerning congressional intent to withdraw the remedies available under § 1983, the defendants have not seriously attempted to discharge their burden of identifying a clear state court remedy, and it appears that none exists.

The Medicaid Act makes no specific provision for federal suits by providers.[38] In certain circumstances, courts have

opportunity of administrative appeal against the agency's initial determinations in accordance with Article 3 of the Virginia APA and the state plan, and the same subsection states that "[c]ourt review of final agency determinations concerning provider reimbursement shall be heard in accordance with the Administrative Process Act." § 32.1-325.1(B). By its own terms, this provision is limited in its application to *individual determinations of overpayment* under the state plan; it can hardly be regarded as an appropriate vehicle for seeking state court review of the validity of the plan itself, or apparently, even of *underpayments*.

[37] The Solicitor General relies exclusively on the Virginia APA for his assertion that the scope of judicial review is not limited in the same manner as the administrative appeals process. U.S. Amicus Br. 6. The Solicitor General specifically cites to Va. Code 9-6.14:17, which governs the issues that may be the subject of review. Presumably, the Solicitor General has in mind the issue identified as "compliance with statutory authority, jurisdiction limitations, or right as provided in the basic laws as to subject matter." Va. Code § 9-6.14:17(ii) (Repl. Vol. 1989). If so, and even if this provision is broad enough to cover the validity of a state plan itself, it is not clear how providers would manage to bypass the grant-of-public-funds exemption. The amendment enabling recipients of public assistance to seek judicial review expressly precludes this kind of challenge, and the provisions governing determinations of overpayment track the state plan, including its limitations.

[38] The Act makes express provision for judicial review of the Secretary's determinations in only one instance: where the Secretary has disapproved a state plan, or amendments to a state plan, submitted to him for approval. In such a case, the *state* may file a petition for review in the court of appeals for the circuit in which the state is

recognized that Medicaid recipients and providers can obtain review of the Secretary's decisions; in so doing, reliance has been placed on the federal Administrative Procedure Act[39] and various federal jurisdictional statutes.[40] In any event, this form of review is extremely limited as a means of challenging compliance with § 1396a(a)(13)(A).[41] In

located. 42 U.S.C. § 1316(a)(3). In other situations, for example where the Secretary has disallowed federal participation because of a violation of a federal standard in the administration of a plan, *id.* §§ 1396b, 1316(d), the courts have held that the Secretary's decision is reviewable in federal district court under the federal APA and jurisdictional statutes, on the petition of the *state* concerned. *See, e.g., Bowen v. Massachusetts*, 108 S. Ct. 2722 (1988); *Minnesota v. Heckler*, 718 F.2d 852, 857 (8th Cir. 1983); *Illinois Dep't of Public Aid v. Schweiker*, 707 F.2d 273 (7th Cir. 1983).

[39] Federal Administrative Procedure Act review is not available against the states because they do not fall within the definition of "agencies" for the purposes of the APA. *See* 5 U.S.C. § 701(b)(1)(1988). *See, e.g., Mary Washington Hosp. v. Fisher*, 635 F. Supp. 891, 897 (E.D. Va. 1985).

[40] For example, Medicaid recipients residing in nursing homes were permitted to bring a class action against the Secretary to require the latter to implement a system of enforcement to ensure compliance by provider facilities with the requisite federal standards. *Estate of Smith v. Heckler*, 747 F.2d 583 (10th Cir. 1984). So, too, the right of providers to seek review against the Secretary in respect of his approval of a state plan was recognized by the courts in the pre-Boren Amendment decisions. *See, e.g., Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388 (5th Cir. 1980); *Hospital Ass'n v. Toia*, 438 F. Supp. 866, 868-69 (S.D.N.Y. 1977); *see also Hospital Ass'n v. Toia*, 473 F. Supp. 917, 924, 925-27, 940 (S.D.N.Y. 1979).

[41] In post-Boren Amendment decisions the courts have been reluctant to extend judicial review to the Secretary's approval process, even when they have been prepared to entertain suits against the states. *See, e.g., Nebraska Health Care Ass'n v. Dunning*, 575 F. Supp. 176 (D. Neb. 1983). (citing changed federal/state relationship brought about by Boren Amendment), *aff'd in pt., vacated in pt.*, 778 F.2d 1291 (8th Cir. 1985) *cert. denied*, 479 U.S. 1063 (1987); *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511, 521–22 (5th Cir. 1983) (refusing to enjoin

view of the limited role played by the Secretary in the formulation of state plans, review of his decisions cannot be regarded as a sufficiently comprehensive remedy, and to the extent that it does not even derive from the Medicaid Act, it can hardly constitute evidence of congressional intent to foreclose remedies under § 1983.

D. The Fragmentary And Uncertain Remedies Available Under The Medicaid Act And Regulations Fall Far Short Of Manifesting An Intent By Congress To Create A Comprehensive Remedial Framework That Forecloses Relief Under Section 1983

The defendants complain that by recognizing that providers have a remedy under § 1983, "the Court of Appeals and the District Court have thwarted and reversed [congressional efforts to reduce federal oversight] by grafting federal judicial review onto the program." "The result," they continue, "is confusing, wasteful of resources and duplicative." Pet. Br. 24. The question the defendants have failed to answer, however, is: "duplicative" of what? Their entire argument begs the question in issue, which is "do providers have a right secured by § 1396a(a)(13)(A)?" None of the "remedies" relied upon provides a satisfac-

implementation of state plan until Secretary defined meaning of "efficiently and economically operated providers" and "hospitals which serve a disproportionate number of low income patients with special needs," and distinguishing *Alabama Nursing Home*, because of changes brought about by Boren Amendment); *Illinois Health Care Ass'n v. Suter*, 719 F. Supp. 1419, 1424 (N.D. Ill. 1989) (to "imply a private right of action against the Secretary would require more than the anticipated limited degree of oversight envisioned for the Secretary"). One court considered the Secretary's role to have been reduced so significantly that it held the Secretary to have properly accepted a state's plan and assurances even though subsequent litigation had shown that those assurances were false. *California Hosp. Ass'n v. Schweiker*, 559 F. Supp. 110, 116 (C.D. Ca. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983); *see also Dunning*, 575 F. Supp. at 179.

tory avenue of redress for the vindication of the right of providers to a state plan that guarantees those who are cost-efficient to reasonable and adequate reimbursement for their services. The alternative state and federal remedies identified by the defendants are neither adequate nor even certain, and they come nowhere close to embodying a comprehensive remedial system supplied by Congress in substitution of the remedy under § 1983. The state appeals system is limited to disputes concerning application of the plan; state judicial review is at best confined to the same issues; federal administrative supervision is not designed to scrutinize the details of payment methodology for compliance with the provider reimbursement standard; and federal judicial review based on the Administrative Procedure Act is, for the same reason, speculative and ineffective as a form of redress.

IV

THE SAFEGUARD OF PROSPECTIVE RELIEF UNDER SECTION 1983 IS WHOLLY CONSISTENT WITH CONGRESS'S INTENT TO AFFORD THE STATES REASONABLE FLEXIBILITY IN DEVISING PAYMENT METHODS UNDER SECTION 1396a(a)(13)(A)

The current Medicaid provider payment system, as interpreted by the federal courts of appeals, faithfully embodies Congress's purposes in enacting § 1396a(a)(13)(A). Congress revised the provider payment provisions in 1980 and 1981 to put primary responsibility "squarely on the States to establish adequate payments" to providers. Statement of Sen. Boren, *supra*, at 845. Congress modified the substantive federal standards for determining the adequacy of payment rates in order to make plain the states' ability to devise plans that varied from the Medicare standard, and reduced sharply the Secretary's role. Participating states are responsible for

developing methods and standards for setting provider payment rates and for finding that the resulting rates do in fact satisfy the federal statutory requirements. The Secretary remains responsible for monitoring the processes by which the states make their findings, but does so through a process that affords providers no formal means of participation or redress. Specific complaints by individual providers over particular rates or payment decisions are handled by the administrative appeals process the states are required to establish. Challenges to the legality of the state payment plan as a whole—which a state need not entertain in its appeals process—are to be adjudicated in "the State and Federal civil court systems," 48 Fed. Reg. at 56,052 (comments on final regulations). The result is a coherent system of enforcement.[42]

The defendants' assertion that the retention of the § 1983 cause of action in cases such as the present one is "confusing, wasteful of resources and duplicative," Pet. Br. 24, is without merit. The

[42] The defendants characterize § 1983 provider suits against state officials as "federal judicial interference" which, if permitted, would "upset the efficiency and workability of the system devised by Congress" and a "special balance" struck by Congress "between federal and state enforcement in creating and maintaining the unique Medicaid Program." Pet. Br. 28-29. This characterization seeks to marshal in the defendants' support Justice Blackmun's indicium of congressional intent to withdraw the § 1983 remedy in *Smith v. Robinson*, 468 U.S. 992, 1012 (1984) ("Allowing a plaintiff to circumvent the EHA administrative remedies would be inconsistent with Congress' carefully tailored scheme"), *quoted in Golden State*, slip op. at 3. On the contrary, provider suits under § 1983 complement the system created by the Medicaid Act and, with the decentralization of responsibilities brought about by the 1980 and 1981 amendments, are more important than ever if state compliance with federal standards is to be assured. Section 1983 provides a judicial "backstop" to ensure the legality of state plans, thereby complementing the necessarily more generalized, advance oversight performed by the Secretary.

defendants have mischaracterized this case as involving an attempt to secure "*de novo* adjudication of payment disputes in the federal courts." Pet. Br. 25. In reality, however, the VHA's action is a systemic challenge to the compatibility of the state's reimbursement principles with the Act, not a dispute over a particular rate or state administrative decision. The VHA seeks declaratory and injunctive relief against a state payment *plan* that does not satisfy the Act's requirements, J.A. 21-22, not against individual state reimbursement decisions. By collapsing the distinction between the plan itself and determinations under the plan, the defendants seek to secure immunity from judicial review of their actions. They assert an immunity even more extensive than that enjoyed by the Secretary himself, *under an express statutory preclusion of review*, with respect to Medicare benefit determinations. *See* 42 U.S.C. §§ 405(h), 1395ii (1982); *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). In *Bowen*, this Court recognized that §§ 405(h) and 1395ii preclude judicial review of individual Medicare benefit determinations, but rejected the contention that they also prevented review of the *methods* by which such determinations were reached.[43] The defendants can identify no express foreclosure of § 1983 review under the Medicaid Act. They attempt to create an implied foreclosure of § 1983 review by pointing to the state administrative process designed to resolve individual claims regarding reimbursement. This argument fails to recognize the fundamental distinction between systemic challenges to method

[43] As the Court observed, "[u]nlike the *determinations* of amounts of benefits, the *method* by which such amounts are determined ordinarily affects vast sums of money and thus differs qualitatively from the 'quite minor matters' review of which Congress confined to hearings by [the Secretary's delegees]. In addition, . . . 'permitting review only [of] . . . a particular statutory or administrative standard . . . would not result in a costly flood of litigation, because the validity of a standard can be readily established, at times even in a single case.' " *Bowen*, 476 U.S. at 680 n.11 (citation omitted).

and individual appeals of particular reimbursement determinations, which the Court recognized in *Bowen*.

The suggestion that Medicaid providers need not be reimbursed in accordance with the congressionally-mandated standards because provider participation is voluntary and a dissatisfied provider may withdraw[44] is equally groundless. For approximately half of the hospitals participating in Virginia's Medicaid program this is not even theoretically a legal possibility because they have received funds under the Hill-Burton Act, 42 U.S.C. §§ 291 *et seq.*, J.A. 17-18, which obligates them to participate in Medicaid.[45] Furthermore, all hospitals with emergency rooms that participate in Medicare are obliged by federal statute to provide emergency treatment to all persons, including Medicaid patients. *See* 42 U.S.C. § 1395dd (1988). To the extent that the option of withdrawal from participation exists, this self-help "remedy" is an inappropriate check on state non-compliance. Relying on provider withdrawal to enforce the Act's requirements would directly contradict the intent of Congress that "payment levels . . . be set at a level that *ensures* the active treatment of Medicaid patients in a majority of the hospitals available in the State," H.R. Rep. No. 158, *supra*, at 293. The policy of the Act is strongly to encourage provider participation, not to drive them away through arbitrary or inadequate payment rates. *See Illinois Hosp. Ass'n v. Illinois Dep't of Public Aid*, 576 F. Supp. 360, 372 (N.D. Ill. 1983).

[44] Pet. Br. 17 n.9; Conn. Amicus Br. 3.

[45] "Although the [Medicaid] Act itself contains no requirement that hospitals participate in the Medicaid program, hospitals that have accepted federal construction funds under the federal Hill-Burton programs *are* required to participate in the Medicaid program. . . . None of [these] hospitals have the option of terminating its participation in the Medicaid program," *Illinois Hosp. Ass'n v. Illinois Dep't of Public Aid*, 576 F. Supp. 360, 366 (N.D. Ill. 1983).

In the final analysis, the defendants' disagreement is with Congress, not with the federal courts that since 1969 have recognized providers' § 1983 cause of action. Congress could have enacted a statute, pledging billions of dollars in federal matching funds, under which the state was under no duty to conform its use of those funds to the statute's standards. Congress could have required the Secretary to continue to engage in direct and intense review of state plans. Congress could have expressly rejected federal litigation over this subject. But Congress did none of these things. Congress chose instead to require states participating in Medicaid to reimburse providers at the level established by the statute. Any decision to rescind the right to receive such reimbursement is a decision that should be made by Congress. As long as the right exists, state and federal courts are empowered to enforce it in actions brought under § 1983.

CONCLUSION

The judgment of the court of appeals below was correct and should be affirmed.

Respectfully submitted,

WALTER DELLINGER
LAWRENCE G. BAXTER
H. JEFFERSON POWELL
Corner of Science Drive
and Towerview Road
Durham, North Carolina
27706
(919) 684-3404

MARTIN A. DONLAN, JR.*
JUDITH B. HENRY
Crews & Hancock
700 E. Main Street
Suite 1015
Richmond, Virginia
23219
(804) 649-9333
Counsel for Respondent
* *Counsel of Record*

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APPENDIX

Federal Statutory Provisions

42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. III 1985) provides as follows:

A state plan for medical assistance must provide for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1396r of this title and provide (in the case of a nursing facility with a waiver under section 1396r(b)(4)(C)(ii) of this title) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care, and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further

assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and periodic audits by the State of such reports.

Former 42 U.S.C. § 1396a(a)(13)(D)(i) (1976) provided as follows:

A State plan for medical assistance must provide for payment (except where the State agency is subject to an order under section 1914) of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII, except that in the case of hospitals reimbursed for services under part A of title XVIII in accordance with section 1814(b)(3), the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section.

42 U.S.C. § 1396a(a)(37)(1982) provides as follows:

A state plan for medical assistance must provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 60 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program.

Federal Regulations

42 C.F.R. § 447.253(b)(1)(i) (1988) provides that:

Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 C.F.R. § 447.253(c)(1988) provides as follows:

The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

State Statutes

Va. Code § 9-6.14:16(B) (Repl. Vol. 1989) provides as follows:

The provisions of this article shall apply to case decisions regarding the grant or denial of aid to dependent children, Medicaid, food stamps, general relief, auxiliary grants, or state-local hospitalization. However, no appeal pursuant to this article may be brought regarding the adequacy of standards of need and payment levels for public assistance programs. Notwithstanding the provisions of § 9-6.14:17, such review shall be based solely upon

the agency record, and the court shall be limited to ascertaining whether there was evidence in the agency record to support the case decision of the agency acting as the trier of fact. If the court finds in favor of the party complaining of agency action, the court shall remand the case to the agency for further proceedings. The validity of any statute, regulation, standard or policy, federal or state, upon which the action of the agency was based shall not be subject to review by the court. No intermediate relief shall be granted under § 9-6.14:18.

Va. Code § 32.1-325.1 (Cum. Supp. 1989) provides as follows:

A. The Director shall make an initial determination as to whether an overpayment has been made to a provider in accordance with the state plan for medical assistance, the provisions of § 9-6.14:11 and applicable federal law. Once a determination of overpayment has been made the Director shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 from the date the Director's determination becomes final. Nothing in § 32.1-313 shall be construed to require interest payments on any portion of overpayment other than the unpaid balance referenced herein. In any case in which an initial determination of overpayment has been reversed in a subsequent agency or judicial proceeding, the provider shall be reimbursed that portion of the payment to which he is entitled plus any applicable interest.

B. An appeal of the Director's initial determination concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) and the state plan for medical assistance provided for in § 32.1-325. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act. This provision shall apply to all administrative appeals pending as of its effective date in which no agency hearing has been held.

State Regulation

Section VI of the Virginia State Plan Under Title XIX of the Social Security Act, Attachment 4.19A, "Methods and Standards for Establishing Payment Rates—In-patient Hospital Care" (effective date 9/1/88) provides as follows:

In accordance with Title 42 §§ 447.250 through 447.272 of the *Code of Federal Regulations* which implements § 1902(a)(13)(A) of the *Social Security Act*, the Department of Medical Assistance Services ("DMAS") establishes payment rates for services that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards.